

Testimony of
Michael Hash, Deputy Administrator
Health Care Financing Administration
on the
Fiscal 1999 Chief Financial Officers' Audit
before the
House Government Reform Subcommittee
on
Government Management, Information & Technology
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Chairman Horn, Congressman Turner, distinguished Subcommittee members, thank you for inviting me to discuss our progress in getting Medicare's financial house in order. I would also like to thank the HHS Inspector General (IG) and General Accounting Office (GAO) for their valuable assistance to us in this effort.

The Clinton Administration has a zero tolerance policy for health care fraud, waste, and abuse. In 1995, we launched Operation Restore Trust, a ground-breaking anti-fraud project aimed at coordinating federal, state, local and private resources in targeted areas. The result is a record series of investigations and convictions, as well as new management tools to fight improper payments.

Since 1996, we have built on these efforts with findings from the Chief Financial Officer's audits through a series of aggressive actions to prevent improper payments and strengthen our financial integrity. The audit findings and GAO reviews serve as roadmaps directing us to needed improvements. We are attacking financial management problems with the same focus and energy that we used to meet our Year 2000 computer challenge, and we intend to be as successful in this as we were in Y2K.

We have seen tangible results from our efforts to address audit findings each year. This year, for the first time, the auditors are able to give us a clean opinion. And the claims payment error rate is holding steady at about half of what it was in 1996, even though this year's sample includes more claims for problem areas such as home health and medical equipment. These results show that our progress is not a one-time phenomenon but something sustainable on which we can build.

We are taking several new steps to further protect Medicare's financial integrity and bring the claims payment error rate down. Key among these are efforts to determine an error rate for every contractor that pays these claims. This will help us focus on specific problems in a far more targeted way than we can with the national error rate, which is extrapolated from claims for just 600 beneficiaries.

Another critical area includes efforts to help providers document and file claims correctly. We will test new documentation guidelines that should be easier for physicians to use. We will expand outreach and education programs to help providers file claims correctly. And we will contact all physicians, home health providers, and medical equipment suppliers in the Medicare program to address documentation problems and explain how to avoid common errors.

We also can expect to see more impact from the many program integrity efforts that we initiated this past year through our comprehensive program integrity plan and other steps.

- We hired special contractors to focus solely on preventing improper payments.
- We greatly strengthened contractor oversight through tighter performance evaluation standards, national evaluation teams, and mandatory corrective action plans.
- And we continue to seek contracting reform legislation so we can use the same contracting rules as other government agencies and expand the range of firms capable of serving Medicare and protecting taxpayer dollars.

We are aggressively addressing financial management issues identified by us, the IG, GAO, and accounting firms with which we have contracted. Most of these issues have their roots in the system established in the 1965 Medicare law, whereby Medicare must contract with private health insurance companies to process and pay claims. We have made significant progress already. We have an ambitious array of further actions planned or underway that are consistent with the GAO report's recommendations. And we are developing a comprehensive business plan to ensure successful implementation of these efforts. I am determined that Medicare and its contractors meet the same high standards of accounting required of major private sector corporations.

Background

Medicare pays more than \$200 billion to one million health care providers for services provided to nearly 40 million seniors and disabled Americans annually. The Government Management Reform Act has required annual audits each year since fiscal 1996, including review of a statistical sample of Medicare claims. That year a 14 percent claims payment error rate and several weaknesses in financial management were identified. We have been working diligently to address these issues ever since.

In response to the fiscal 1996 audit, we took several actions to address the most serious problems first. We contracted with Ernst & Young to help us clean up our accounts payable. We funded an audit to address concerns about the Social Security Administration process for withholding Supplemental Medical Insurance Premiums.

We also initiated several other actions to address the error rate that included:

- increasing the level of claims review and the number of physician medical directors who lead claims review activities for contractors;
- expanding the number and scope of computer "edits" that identify improper claims before they are paid;
- developing stricter enrollment safeguards to keep illegitimate providers from billing Medicare; and
- organizing a national fraud, waste, and abuse conference and using lessons learned to begin developing a comprehensive program integrity plan.

The fiscal 1997 audit verified our success in addressing issues with our accounts payable and the Social Security Administration. Also that year, the payment error rate dropped to 11 percent.

Following the fiscal 1997 audit, we took action to clarify our handling of cost reports and the Medicaid payables and receivables to the auditors' satisfaction, and made progress in the remaining areas of concern raised by the auditors.

We also:

- made further increases in the level of claims reviews;
- began conducting site visits nationwide to ensure that durable medical equipment providers were in fact, legitimate businesses; and
- set stricter enrollment criteria to keep unscrupulous medical equipment providers and home health agencies out of the program.

Strengthening Contractor Oversight

Among the most important actions we took following the fiscal 1997 audit were steps to substantially strengthen oversight of the private insurance companies that, by law, process Medicare claims and thus carry out critical financial management functions. We consolidated responsibility for contractor management by establishing the new position of Deputy Director for Medicare Contractor Management. And we created a Medicare Contractor Oversight Board to set policy regarding contractor-related activities. These steps are proving to be critical as we move forward to address remaining issues.

The fiscal 1998 audit revealed more substantial results from our actions. The payment error rate was down to 7.1 percent, and only one area - accounts receivable - kept us from receiving a clean opinion.

In response to the fiscal 1998 audit, we hired independent Certified Public Accounting firms to assist us in an extensive analysis of accounts receivables that validated more than 80 percent of the outstanding debt. As a result, we identified \$2.6 billion in outstanding receivables, some as much as 10 years old, most of which should have been paid by other insurers.

As required by the Debt Collection Improvement Act, we will aggressively pursue this debt and, when appropriate, refer cases to the Treasury Department for further collection activity and

litigation. In accordance with policy of the federal Chief Financial Officers' Council, we are removing these receivables from our financial statements so the statements reflect accurate economic value.

We also removed about \$300 million in debt that is as much as 10 years old with no potential for collection from our financial statements. Some of these debts exceed the statute of limitations for collection.

Our accountants also identified \$1.3 billion in adjustments from the books of our claims processing contractors, and these also were removed from our financial statements. We are requiring these contractors to implement corrective actions so they comply with generally accepted accounting principles and prevent these types of errors from recurring.

Also in the past year we:

- implemented our comprehensive program integrity plan, which details our overall strategy to reduce waste, fraud and abuse;
- hired independent Certified Public Accounting firms to analyze internal control systems at 25 of the largest and highest-risk Medicare contractors, representing 80 percent of Medicare fee-for-service payments;
- created standardized reporting and evaluation protocols and used national review teams to evaluate contractors' fraud and abuse efforts and other key functions;
- directed each contractor to implement corrective action plans to ensure that they can track funds more accurately;
- notified the contractors of our intent to amend our contracts with them to require details and time frames for correction of each deficiency identified;
- hired our first-ever national contractor to ensure Medicare does not pay claims that private insurance companies should pay;
- initiated steps to develop an integrated general ledger system to standardize the accounting systems used by all contractors; and
- created and filled a new high-level management position to coordinate the agency's business plans to further strengthen financial controls.

Fiscal 1999 Results

Our Government Performance and Results Act goal for 1999 was an error rate of 9 percent. The new fiscal 1999 payment error rate estimate is 7.9 percent, which is not a statistically significant change from the fiscal 1998 error rate. Due to the limited size and variance of the sample, the true error rate could range from 5.4 to 10.6 percent. We are committed to achieving our goal for 2002 of 5 percent.

The error rate plateau shows that our actions have achieved sustainable improvement. And it is noteworthy that the rate remained stable even though the fiscal 1999 sample included more home

health and durable medical equipment claims -- areas where problems have been more common.

The clean audit opinion reflects our success in improving Medicare's financial systems to increase the efficiency and accuracy of our financial statements in accordance with standard accounting practices. This is an essential step in assuring that Medicare's financial status is accurately portrayed so that the most effective subsequent steps can be taken toward sounder day-to-day financial management. Several of these on-going reforms directly address contractor issues.

Contractor-specific Error Rates

While the national error rate has helped us focus our efforts on preventing improper payments, we need stronger tools to uncover the real problem areas. Key to this effort is our proposal to develop contractor-specific error rates. For each contractor, we will conduct reviews for a statistically valid sample of claims and determine whether the contractor paid the claim accurately. The review will determine whether health-care providers were underpaid or overpaid for the sampled claims. The results will reflect not only the contractor's performance, but also the billing practices of the health-care providers in their region. Contractors will then develop targeted corrective action plans to reduce payment errors through provider education, claims review and other activities.

We will establish baselines and then track each contractor's rate of improvement. The results will guide contractor's plans to reduce errors much as the overall Medicare error rate has guided our national improvement efforts. We will begin this summer by determining error rates for the companies that process nearly 50 million claims each year for medical equipment and supplies for beneficiaries nationally, and we plan to perform similar evaluations for all claims-processing contractors.

Additional efforts focused on contractors include:

- **Strengthening contractor oversight.** The President's Fiscal Year 2001 budget requests \$48 million for new positions at the contractors and HCFA to tighten financial controls and ensure a swift, coordinated response to waste, fraud, and abuse. The budget also includes a provision for HCFA to competitively contract with a qualified entity to audit and evaluate financial management systems.
- **Issuing contractor report cards.** We are working with the IG to create report cards on each contractor's performance against specific goals and criteria. Contractors that perform poorly and fail to improve risk losing their Medicare business.
- **Requiring corrective action plans.** We have already requested corrective action plans from contractors for problems identified in the fiscal 1999 audit. We have developed written procedures for requesting, tracing, and disseminating such corrective action plans, including time frames for evaluating them. Each contractor must include a detailed description of each problem, specify details of actions and time frames to resolve them, and submit quarterly reports on their progress. We plan to hire a Certified Public Accounting firm to evaluate how effective these corrective actions are. And, we will include review of corrective action plan effectiveness in our standardized Contractor

Performance Evaluation process.

- **Strengthening Regional Office coordination.** We are consolidating responsibility for contractor management among our 10 regional offices by establishing four Consortium Contractor Management Officers. They will be accountable for management of specific contractors and oversee staff with primary responsibility for contractor management.
- **Seeking contracting reform.** We continue to seek contracting reform legislation to allow Medicare to use all firms capable of processing claims and protecting program integrity. Existing law requires Medicare to use only health insurance companies to process claims, and allows some providers to choose their claims processor. This has hampered our program integrity efforts, as the commitment to these efforts has varied widely among these contractors. And some of these insurance companies themselves have been convicted of violating Medicare program integrity. The IG and GAO have agreed that we need to create an open marketplace so we do not have to rely on a steadily shrinking pool of insurance companies and can bring Medicare contracting in line with standard contracting procedures used throughout the Federal government.

Financial Management

We are also taking several steps to address financial management issues. These include:

- **Developing an integrated financial management system.** We continue to work towards an integrated financial management system to standardize the accounting systems used by all contractors. The project, which will make it easier to coordinate and reconcile data, is scheduled for completion by 2004, pending the results of the assessment phase currently underway. The President's Fiscal Year 2001 budget requests \$7 million to support this essential project.
- **Consolidating accounting functions.** We are consolidating all accounting and CFO Act reporting functions in one organization. And we are establishing a new division to concentrate on internal controls and risk adjustment, and ensure that procedure guidelines and accounting policies are written, designated, and implemented.
- **Assessing staff needs.** We are engaged in an agency-wide planning effort to assess staffing needs, including those for financial management. We also will consult with outside experts to help us develop staff skills in financial analysis and other pattern analysis techniques that can help identify potential problems. In the meantime, we have initiated a short-term project to organize regional office staff currently involved with contractor oversight in order to facilitate better national coordination of efforts. And we are assessing other resource needs for optimal contractor oversight.
- **Improving guidance to contractors.** We are developing a financial management internal control manual with standards for evaluating contractors' financial management performance. We are working with an outside consultant who plans to seek further input from contractors, and then create a database that we can post on the Internet with all our financial management guidance and instructions for contractors. We expect this to be completed by September. In the meantime, we will clarify for contractors our instructions

for allocating cash receipts between the two Medicare trust funds. We also will update our manual of instructions for contractors on a yearly basis to incorporate results from oversight and evaluation efforts by us, the IG, and GAO.

- **Developing comprehensive financial management plan.** We are developing a comprehensive financial management business plan to identify the strategies that will achieve our objectives. This is being led by our newly created position of Associate Director for CFO Audits and Internal Controls, and should be completed this summer.

Protecting Data

Protection of beneficiary data is one of our highest priorities. We have made some progress in addressing audit findings about systems security, and expect to make more substantial progress now that we have met our Year 2000 information systems requirements.

- We are moving aggressively to address all audit findings concerning security vulnerabilities and expect these problems to be resolved by October 1, 2000.
- We have established a Beneficiary Confidentiality Protection Board to develop and enforce a comprehensive privacy policy
- We are developing a robust security architecture that will provide a solid foundation for building security into all of our systems development and maintenance activities, both internally and at our contractors.
- We are assessing new technology for securing internet-based transactions.
- We are providing security awareness training for all employees and ensuring that there are security and contingency plans for all of major systems and applications.
- We are working closely with other HHS components to develop a department-wide strategy for implementing Presidential Decision-Directive 63, which requires federal agencies to take aggressive measures to protect critical information infrastructure from cyber-terrorism.

Error Rate Reduction

To bring the payment error rate down further, we are:

- Ensuring proper payment. We will continue to aggressively work to reduce the payment error rate to below 5 percent by fiscal 2002 through our comprehensive program integrity plan and other efforts. Although Medicare pays virtually all claims correctly based on the information submitted, improper payments occur for reasons such as insufficient documentation, lack of medical necessity, and improper coding by providers. The error rate does not measure fraud, but can include improper payments related to fraudulent conduct.
- Focusing on inpatient care. Medicare's physician-led Peer Review Organizations are working with hospitals to investigate, correct, and prevent claims that are improperly

coded, insufficiently documented, or for unnecessary or uncovered services. Our new contracts with them include strong financial incentives for them to reduce improper payment rates for inpatient care.

- **Hiring special program integrity contractors.** Using specific contracting authority provided by HIPAA, we last year chose 13 companies, including financial management and technology companies, as our first-ever contractors devoted to protecting the Medicare Trust Fund. These contractors, who have health care expertise, will help us tackle key tasks, including audits, medical reviews, data analysis, site visits, and provider education.
- **Expanding the correct coding initiative.** We will continue to expand the correct coding initiative, which uses roughly 100,000 computer edits to identify improper claims before Medicare pays them. Begun in 1994, the initiative prevents more than \$250 million in improper payments each year.

Working with Providers

We also are continuing efforts to help providers file and document claims correctly. This is particularly important, as the current audit shows that the error rate plateaued largely due to a sharp increase in documentation problems since last year. Missing or inadequate documentation accounted for 41 percent of errors in the current audit, which is more than double the rate of such problems found last year.

To help providers file claims properly, we are:

- **Testing new documentation guidelines.** We will this year begin testing new guidelines for physicians on how to document evaluation and management services, which constitute the majority of Medicare claims. The guidelines will help ensure Medicare pays claims correctly while minimizing the paperwork burden for doctors.
- **Expanding provider education.** We will expand efforts to help doctors, hospitals, and other providers learn how to properly file and document claims. This includes innovative computer courses on our web site on the proper filing and documentation of claims, as well as satellite broadcasts and other efforts.
- **Contacting key providers.** We will directly contact all physicians, home health providers, and durable medical equipment suppliers in the Medicare program to address documentation problems and explain how to avoid common errors.
- **Initiating Progressive Corrective Action.** We are undertaking a new initiative in which we will share more feedback with providers, both on an individual and community level, about how to correct and prevent the types of errors identified in medical review of claims. We believe this can have a substantial impact in reducing improper claims among the vast majority of providers who make only honest errors.

CONCLUSION

Protecting program integrity and strengthening financial management and contractor oversight

are our top priorities now that we have met our Year 2000 obligation. The findings of this year's audit and the GAO report on financial management will once again serve as a roadmap guiding us to further improvements.

We look forward to working with Congress, our IG and GAO colleagues, and our contractor and provider partners to ensure that we meet our obligation to pay claims properly, fight fraud, waste, and abuse, and responsibly manage Medicare finances.

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